

HRS Patient

Due to the current times we are in with COVID-19 on the uprise we are asking all patients to take a few minutes to fill out this questionnaire. All answers will be confidential and will be reviewed by the practice clinician who will provide guidance regarding any adjustments that may need to be made to your appointment if yes is answered to any of the questions.

1. Have you or anyone in your household had **ANY** of the following symptoms in the last 21 days:
 - Fever at or greater than 100 degrees Fahrenheit
 - Cough
 - Headache
 - Body aches or chills
 - Shortness of breath
 - Loss of taste or smell
 - Sore throat
 - Diarrhea, nausea, vomiting
 - Congestion or runny nose
2. Have you or anyone in your household been tested for COVID-19?
3. Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or health care facility in the past 30 days?
4. Have you or anyone in your household traveled within the U.S. in the past 21 days?
5. Have you or anyone in your household traveled on a cruise ship in the past 21 days?
6. Have you or anyone in your household traveled out of the U.S in the past 21 days?
7. Are you or anyone in your household a health care provider or emergency responder?
8. Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?
9. Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?
10. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?